STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155576	A. BUILDING 00 B. WING	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	0548 S 100 W HARTFORD CITY, IN 47348

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 11, 12, 13, 14 and 15, 2016 Facility number: 000289 Provider number: 155576 AIM number: 100289460 Census bed type: SNF/NF: 48 SNF: 5 NF: 0 Total: 53 Census payor type: Medicare: 7 Medicaid: 37 Other: 9 Total: These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on July 19, 2016.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide personalized activity's programming for 2 of 3 cognitively impaired residents reviewed for activities (Resident #41 and #66). Findings include: 1. On 7/12/16 at 10:34 a.m., Resident #41 was laying in bed with her eyes closed. On 7/12/16 at 11:18 a.m., Resident #41 was laying in bed with her eyes closed. A coffee and news activity was taking place on the front porch. On 7/12/16 at 2:30 p.m., Resident #41 was sitting in her room in her wheelchair. A bible study activity was taking place in the dining room. On 7/13/16 at 10:02 a.m., Resident #41 was sitting in her room in her wheelchair	F 0248	Miller's Merry Manor respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation F 248. It is the policy ofMiller's Merry Manor, Hartford City, to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. 1.Residents # 41 and #66 have been offered/placed in activities that are appropriate for their cognition and level of functioning. Each resident will be assisted and encouraged to participate in activities at their level of functioning. 2.All cognitively impaired residents have the potential to be affected by this deficient practice. Each resident's comprehensive assessment will be reviewed. Residents will be assisted and encouraged to participate in activities at their level	08/11/2016

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	with the TV on and her eyes closed. On 7/13/16 at 11:09 a.m., Resident #41 was in bed with the TV on and her eyes closed. A coffee and newspaper activity was taking place in the dining room. On 7/13/16 at 12:48 p.m., Resident #41 was sitting in her wheelchair at a dining room table with her eyes closed. On 7/14/16 at 7:34 a.m., Resident #41 was sitting in her room in her wheelchair with the TV on. A large calibrated medication cup was laying empty on her lap. On 7/14/16 at 9:22 a.m., Resident #41 was in bed with her eyes closed. On 7/14/16 at 10:00 a.m., Resident #41 was in bed with her eyes closed. On 7/14/16 at 1:38 p.m., Resident #41 was in sitting in her room in her wheelchair with the TV on with no volume. She was awake and gazing around her room. On 7/14/16 at 2:07 p.m., an announcement for an expressive arts and creative writing activity was made on the overhead speaker.		offunctioning. 3.A restructured "Life enrichmentactivity program" has been developed which provides activities for all levels of cognition. There is a specific focus on activities for residents who have cognitive impairments. There are a variety of activities which reach the resident at their level of functioning. These residents will be identified based on BIMS SCORE, Activity Assessments, and MDS assessments. These activities will be in small groups with the length of activity to be appropriate for the resident's attention span. The resident's participation will be monitored to track attendance/interests and changes will be made as necessary. The Activity Department will be educated on appropriate activities for resident's level of cognition and function. 4.The QA tool titled "Life Enrichment for Cognitively Impaired Residents" (Attachment C) has been developed. It will be completed on 25% of the cognitively impaired population weekly for 8 weeks, and then quarterly thereafter per the facility Quality Improvement Program. Any identified issues will be addressed immediately. Concerns/Issues will be logged on the "Quality Improvement Summary Log" (Attachment B) and reviewed/revised monthly in the facility QA Meeting.	

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	On 7/14/16 on 2:09 p.m., Resident #41 was in bed with the TV on and her eyes closed. On 7/14/16 at 3:13 p.m., Resident #41 was sitting in her wheelchair at a table during an "Expressive Arts and Creative Writing" activity in the dining room. There were no materials on the table in front of the resident. On 7/15/16 at 8:40 a.m., Resident #41 was sitting in her wheelchair in her room with the TV on and her eyes closed. On 7/15/16 at 10:20 a.m., Resident #41 was in bed with the TV on and her eyes closed. On 7/15/16 at 11:09 a.m., Resident #41 was being propelled by a staff member to her room and past the dining room, where a coffee hour activity was taking place. On 7/15/16 at 11:28 a.m., Resident #41 was sitting in her wheelchair in her room, with the TV on and her eyes closed. An activity involving playing old records was taking place in the dining room. Review of Resident #41's clinical record began on 7/12/16 at 1:19 p.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, anxiety,		5.Allsystemic changes will be in place by 8/11/16.	

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	and depression. Resident #41 had a 4/4/16, Quarterly MDS (Minimum Data Set) assessment, which indicated she was severely cognitively impaired and required extensive assistance with transfers and locomotion. Review of an Activity Assessment, dated 7/7/16, indicated Resident #41 enjoyed activities including, but not limited to, word searches and crossword puzzles, reading historical and romance books, card games, gospel and dance music, arts and crafts, current events, and outdoor activities. The assessment further indicated she required assistance to and from activities. The assessment indicated the resident actively participated in activities including, but not limited to, bingo, Yahtzee, current events, music, and sitting on the porch. Resident #41 had a current activities careplan, indicating she preferred not to attend group activities, but as of 6/17/16, had been attending bingo, coffee hour, refreshments, beauty shop, sitting on porch, sensory, special events, bible study, church, and music. Interventions included, but were not limited to, going outside, TV or radio as requested, and providing with an activity calendar for			

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	resident to notify staff when she desired to attend an activity. Review of an activity log for Resident #41 for July 2016, indicated she had attended activities including, but not limited to bingo, current events, refreshments, sensory group, reminisce, and beauty shop from 7/1-7/9/16. The log further indicated Resident #41 had only attended sensory group three times from 7/10-7/15/16, with active participation on one day. During an interview, on 7/14/16 at 10:34 a.m., BNA #30 indicated she asked each resident if they want to go to scheduled activities. She indicated she was not aware of which resident enjoyed which activity, so if they could not answer her, she just took them if it seemed like something they would like to go to. During an interview, on 7/14/16 at 10:46 a.m., CNA #18 indicated she took cognitively impaired residents to activities they seemed to enjoy, such as music. She further indicated staff just focused on trying to invite everyone to everything. She indicated Resident #41 did not participate in many group activities. CNA #18 also indicated she was not aware of what the sensory group was, nor was she aware of any activities			

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	taking place at lunchtime. During an interview, on 7/14/16 at 1:07 p.m., Activity Aide #13 (AA) indicated she announced activities on the overhead speaker and invited every resident personally. She indicated she tried to have conversations with the cognitively impaired residents, and some of them responded to her. She indicated Resident #41 would come to coffee hour and bingo sometimes, but didn't always participate. She indicated she wasn't aware of what Resident #41 participated in, because AA#13 was part-time. On 7/15/16 at 10:44 a.m., AA #15 indicated she invited everyone to every activity. She indicated she wasn't aware of who attended the sensory group, but it was the first two tables in the dining room near the TV at lunchtime. She indicated Resident #41 spoke, but was usually non-sensical, so she usually pushed her wheelchair to take her on walks or put lotion on her hands. She further indicated Resident #41 attended group activities, but was "not always thrilled about it" and didn't always participate. She indicated Resident #41 would sit in bingo, but didn't play. She indicated again that they invite everyone to every activity and if it wasn't documented in the activity log, the			

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	resident had refused to go. During an interview, on 7/15/16 at 11:10 a.m., BNA #33 indicated Resident #41 was usually laid down after meals, as she required the use of a Hoyer lift and two staff members for transfers. She indicated Resident #41 did not participate in many activities, as she was usually in bed between meals. During a phone interview, on 7/15/16 at 2:17 p.m., the Activity Director (AD), indicated there were not specific activities for specific residents, that the staff just knew by communicating with each other. She indicated if a resident was up out of bed, then staff knew to bring them to the scheduled activities. She indicated Resident #41 had some days that were better than others, but attended bingo, Yahtzee, and creative writing activities. She indicated her level of participation would vary. She further indicated Resident #41 would attend activities before lunch, when asked how Resident #41 attended activities if she went to bed in between meals. 2. On 7/12/2016 at 10:08 a.m., Resident #66 was in her meri-walker in the hallway. On 7/12/2016 at 10:35 a.m., Resident #66 was in her meri-walker in the hallway			

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	On 7/12/2016 at 2:20 p.m., Resident #66 was in her meri-walker near the main dining room. On 7/13/2016 at 9:56 a.m., Resident #66 was sitting in her room in her meri-walker. On 7/13/2016 at 10:06 a.m., Resident #66 was sitting at the nurses station in her meri-walker. On 7/13/2016 at 10:50 a.m., Resident #66 was in the hallway in her meri-walker. On 7/13/2016 at 11:11 a.m., Resident #66 was in bed asleep while a coffee and current events activity took place in the main dining room. On 7/13/2016 at 12:34 p.m., Resident #66 was in her meri-walker at the front door. On 7/13/2016 at 3:00 p.m., Resident #66 was in her meri-walker at the door to therapy. No activities going on at that time. On 7/13/2016 at 3:33 p.m., Resident #66 was in her room while the sit and stretch activity was going on in the tv lounge.			

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	On 7/14/2016 at 9:54 a.m., Resident #66 was in bed. On 7/14/2016 at 11:17 a.m., Resident #66 was in bed asleep while the coffee and current events activity was taking place in the main dining room. On 7/14/2016 at 1:33 p.m., Resident #66 stood and released her meri- walker. Resident #66 was saying that she needed to "get those wheel chairs done because someone just took off in one." RN #38 asked her if she wanted to walk, closed the meri walker with Resident #66 inside, and walked away leaving Resident #66 in the hallway. On 7/14/2016 at 2:54 p.m., Resident #66 was in bed asleep while the expressive arts activity was going on in the small dining room. On 7/14/2016 at 3:28 p.m., Resident #66 was in bed asleep in bed. On 7/15/2016 at 11:18 a.m., Resident #66 was ambulating in her meri-walker in the hallway just outside the small dining room while an activity involving music and coffee was taking place in the small dining room.			

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	The record for Resident #66 was reviewed on 7/12/2016 at 9:39 a.m. Resident #66 had current diagnosis which included, but were not limited to, unspecified dementia with behavioral disturbance, restlessness, agitation, unspecified psychosis due to a substance or known psychological condition, hallucinations, insomnia, anxiety disorder. Resident #66 had a, 6/14/2016, Quarterly, Minimum Data Set (MDS) assessment which indicated Resident #66 was severely cognitively impaired. The "Activity-Quarterly Assessment," dated 6/15/2016, for Resident #66 was provided by the DON on 7/15/2016 at 7:23 a.m. It indicated activities for Resident #66 actively participated included, but were not limited to, special events, current events, refreshments, church and exercise. The self initiated activities listed included, but were not limited to, walking in meri-walker in the halls, visiting with staff and peers in halls and reading at times. Resident #66 had a current care plan, dated 11/6/2015, with a focus of "ACTIVITIES: Resident enjoys the benefits of increased socialization/stimulation through activity			

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	involvement. Resident is very social, accepts invitation to most activities." The goal indicated Resident #66 would "attend a daily activity for socialization /stimulation or be occupied with an individual activity of interest." Interventions included, but were not limited to, "staff will offer a chair and sit by resident at activities and the activities department will provide resident with newspaper/books/magazines to read." Review of an activity log for Resident #66, for July 2016, indicated she had attended activities including, but not limited to bingo, pet visits, refreshments, and special events from 7/1-7/9/16. The log further indicated Resident #66 had attended activities three days from 7/1-7/8/16. No activities were recorded for 7/9-7/15/2016. During an interview with CNA #18 on 7/14/2016 at 3:25 p.m., she indicated she usually went to Resident #66 to tell her about what activities were happening that day. CNA # 18 indicated Resident #66 usually would stay about five minutes and then leave. CNA #18 indicated Resident #66 liked to roam around the building and that she liked cookies and music. CNA #18 indicated Resident #66 went to activities on her own and did not require assistance in getting there.			

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	During an interview with Activity Aide #13 (AA) on 7/14/2016 at 1:07 p.m., she indicated she did one to one activity with the residents who seldom or never leave their rooms. AA #13 indicated she usually worked weekends and was filling in this week while the Activity Director was on vacation. AA #13 indicated Resident #66 was not seen by the activity department for one to one activities. AA 13 # indicated Resident #66 liked to play bingo. AA #13 indicated Resident #66 usually did not stay in any activity for very long. During an interview with AA #15 on 7/15/2016 at 10:44 a.m., she indicated the residents who are cognitively impaired receive sensory and reading "for the ones that can hear." She further indicated Resident #66 did not receive sensory activity but did receive one to one activity. During a phone interview, on 7/15/16 at 2:17 p.m., the Activity Director (AD), indicated there were not specific activities for specific residents, that the staff just knew by communicating with each other. She indicated if a resident was up out of bed, then staff knew to bring them to the scheduled activities. She indicated Resident #66 liked to go to			

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	current events on the porch and bingo. AD indicated that if Resident #66 was out of her meri-walker she stayed in the activity longer and that some days Resident #66 was not directable and would not stay in any activities. Review of a policy, titled "Life Enrichment Program Guidelines", dated 10/3/13, and provided by the DON on 7/15/16 at 7:23 a.m., indicated the following: "...1. PURPOSE: A. To enhance the lives of our residents through activity involvement...2. A. Evaluate the level of functioning for current population. Using the "levels of Dementia" guide sheet. B. Offer at least 2 activities daily for each of the 3 groups...II. Level 3/4 (will avoid activities requiring new learning) Provide "no fail" activities- activities they are comfortable doing a. utilize daily chronicles-(news from 50 years ago- will interest them) ... c. cooking, d. exercise...f. special events. III. Level 1/2 (these are your lowest functioning typically the ones who sleep during activities- they need sensory stem [sic]) a. Sensory stem [sic]- daily before lunch and supper- this will wake them up and stimulate the appetite...b. Musical programs c. Spiritual activities d. Gross Motor movement exercises- slow repetitive movements i.e. repetitively			

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	clapping hands to music, etc. at least 2 times a week...." 3.1-33(a)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observations, interview and record review, the facility failed to ensure medications were given with clinical indication. Furthermore the facility failed to identify and track targeted behaviors for a resident taking antipsychotic medication with a dementia diagnosis for 1 of 5 residents reviewed for unnecessary medications (Resident #66). Findings include: On 7/12/2016 at 10:08 a.m., Resident #66 was in her meri-walker in the hallway. On 7/12/2016 at 10:35 a.m., Resident #66 was in her meri-walker in the hallway	F 0309	Miller's Merry Manor respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation F 309. It is the policy of Miller's Merry Manor, Hartford City to provide to each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1.Resident #66: The facility has reviewed and updated the clinical indication for use of the resident's antipsychotic medication. The behavior tracker has also been modified to track the targeted behavior for which the antipsychotic medication is	08/11/2016

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	On 7/12/2016 at 2:20 p.m., Resident #66 was in her meri-walker near the main dining room. On 7/13/2016 at 9:56 a.m., Resident #66 was sitting in her room in her meri-walker. On 7/13/2016 at 10:06 a.m., Resident #66 was sitting at the nurses station in her meri-walker. On 7/13/2016 at 10:50 a.m., Resident #66 was in the hallway in her meri-walker. On 7/13/2016 at 11:11 a.m., Resident #66 was in bed asleep while a coffee and current events activity took place in the main dining room. On 7/13/2016 at 12:34 p.m., Resident #66 was in her meri-walker at the front door. On 7/13/2016 at 3:00 p.m., Resident #66 was in her meri-walker at the door to the therapy room. On 7/13/2016 at 3:33 p.m., Resident #66 was in her room in her meri-walker. On 7/14/2016 at 9:54 a.m., Resident #66 was in bed.		ordered. 2.All residents who are receiving antipsychotic medications have the potential to be affected. All residents receiving antipsychotic medication will be reviewed to ensure that proper clinical indication for the medication is present and also that appropriate targeted behaviors are being tracked. 3. 1.The facility will re-educate the nursing staff on use of antipsychotic medications and the clinical indications required for the use of these medications. The staff will also be re-educated on the behavior tracking system. 2.The corporate QA consultant will also be providing re-education to the SSD regarding the requirements and monitoring required for residents receiving antipsychotic medications by 8/11/16. This includes all admission orders, new orders for existing residents, and ongoing monitoring. 3.The facility will continue the monthly behavior meeting in which psychoactive medications are reviewed to ensure appropriate diagnoses are in place and to review the effects of the medication. The pharmacist and the Psych NP participate in this monthly meeting. The facility will also continue to review all new orders/changes for	

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	On 7/14/2016 at 11:17 a.m., Resident #66 was in bed asleep. On 7/14/2016 at 2:54 p.m., Resident #66 was in bed asleep. The record of Resident #66 was reviewed on 7/12/2016 at 9:39 a.m. Resident #66 had current diagnoses which included, but were not limited to, unspecified dementia with behavioral disturbance, restlessness, agitation, unspecified psychosis due to a substance or known psychological condition, hallucinations, insomnia, and anxiety disorder. Resident #66 had a, 6/14/2016, Quarterly, Minimum Data Set (MDS) assessment which indicated Resident #66 was severely cognitively impaired and she did not display any hallucinations, delusions or behaviors during the assessment period. Resident #66 had a current physician's order for Risperdal (antipsychotic) 0.25 mg twice per day. Resident #66 had a weight of 151 on 4/6/2016. Resident #66 had a recorded weight of 135 on 6/3/2016 (which is a 16 lb weight loss in 60 days).		antipsychotic medications per facility policy and procedure to ensure proper clinical indication is present and targeted behavior monitoring is in place. 4.To ensure this does not reoccur the SSD/Designee will complete the Quality Improvement audit tool "Psychopharmacological Medication Review" (Attachment D) The tool will be completed on 25% of the resident population monthly for four months and then quarterly thereafter per the facility Quality Improvement Program. Any identified issues will be addressed immediately and logged on the "Quality Improvement Problem Summary Log" (Attachment B). This will be followed and reviewed through the monthly facility Quality Improvement meeting. 5.All systemic changes will be in place by 8/11/2016.	

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	During an interview with the Social Service Director (SSD) on 7/14/2016 at 10:39 a.m., she indicated Resident #66's tracked behavior was restlessness. The SSD indicated Resident #66 worried about things she needed to do. The SSD indicated Resident #66 had not had any hallucinations "for quite some time" and the staff did not currently track any behavior related to hallucinations. The SSD indicated Resident #66's psychotic behavior was "she thinks she has to work- she is very busy all the time". The SSD indicated Resident #66 was "pleasantly confused". The SSD indicated the interventions for Resident #66's restless behavior included to redirect, assess for pain, and to allow her to stand and walk outside of the meri-walker and that these interventions were successful. During an interview with the Director of Nursing (DON) on 7/14/2016 at 10:49 a.m., she indicated Resident #66 had a diagnosis of dementia with psychosis and hallucinations. She indicated prior to taking the Risperdal, Resident #66 was restless and a constant worrier. The DON indicated Resident #66 was an administrator in another building similar to their's and she still thought she was at work. She indicated Resident #66's dose of Risperdal was increased in February			

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	due to having more episodes of restlessness and hallucinations. During an interview with LPN #34 on 7/14/2016 at 10:55 a.m., she indicated she was familiar with Resident #66 and did not know of any specific behaviors Resident #66 displayed or that they were tracking. During an interview with the SSD on 7/14/2016 at 12:52 p.m., she indicated Resident #66 was seeing small children in January and that was why the Risperdal was increased. During an interview with the DON on 7/14/2016 at 1:42 p.m., she indicated the behaviors that Resident #66 were having now were "more dementia related than psychosis related." During an interview with CNA #2 on 7/14/2016 at 3:25 p.m., she indicated she was familiar with Resident #66 and had not seen Resident #66 display any psychotic behaviors. CNA #2 indicated restlessness was the only tracked behavior for Resident #66. Resident #66 had a care plan, revised 2/7/2016, for a focus of "BEHAVIOR: Behavior #1: resident displays mood issues as exhibited by: restlessness such			

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	as worrying about things she needs to do. Dx. [diagnosis] of dementia with psychosis and hallucinations." The goal was "resident will have no adverse S/E [side effects] from medication through next review." Interventions included but were not limited to, "document mood behavior #1: restlessness such as worrying about things she needs to do, assess for pain, allow to stand / take for walk, move to calm area, offer to call daughter." The admission orders for Resident #66, dated 10/23/2015, were provided by the DON on 7/15/2016 at 7:23 a.m. They indicated an order for Risperidone 0.5 mg twice daily for "dementia with agitation." The "Rounding Providers Psych Progress Note" for Resident #66 was dated 1/4/2016. It was provided by the DON on 7/15/2016 at 7:23 a.m. and indicated "S: patient seen for psychiatric assessment of anxiety, depression and dementia symptoms. Staff reports patient with 13 episodes of agitation, and 9 episodes of hallucinations. Staff reports patient is difficult to redirect at times...." The "Rounding Providers Psych Progress Note" for Resident #66 was dated 7/6/2016. It was provided by the DON on 7/15/2016 at 7:23 a.m. It indicated			

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	"S: patient to be seen for psychiatric assessment of anxiety, depression, dementia, insomnia. Continued evaluation of efficacy of psychotropic medications, continues assessment of moods and behaviors...O...patient states, "no", patient shows obvious signs of delusions, hallucinations, paranoia and suicidal idiations [sic]...Treatment Plan Dementia w. / behavioral disturbances a. continue Risperdal .25 mg po [by mouth] BID [two times per day]...." Behavior tracking for Resident #66 for Behavior #1- Restlessness was provided by DON on 7/15/2016 at 7:23 a.m., indicated the following: January 5, 2016 through January 31, 2016 documented behavior 23/27 days with non-pharmacological interventions listed as successful 47/47 times. February 1, 2016 through February 21, 2016 documented behavior 16/21 days with non-pharmacological interventions listed as successful 22/22 times. March 3, 2016 through March 31, 2016 documented behavior 10/23 days with non-pharmacological interventions listed as successful 17/17 times. April 1, 2016 through April 30, 2016			

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	documented behavior 17/ 30 days with non-pharmacological interventions listed as successful 20/ 20 times. May 1, 2016 through May 31, 2016 documented behavior 6/ 31 days with non-pharmacological interventions listed as successful 8/8 times. June 1, 2016 through June 30, 2016 documented behavior 6/ 30 days with non-pharmacological interventions listed as successful 6/ 6 times. July 1, 2016 through July 14, 2016 documented behavior two of 14 days with non-pharmacological interventions listed as successful two of two times. A document titled "GDR schedule for [name of Resident #66]" was provided by the DON on 7/15/2016 at 7:23 a.m. It indicated the following: "Risperdal 10-23-15 0.5 mg Risperidone po BID 12-16-15 decrease Risperidone to 0.5 mg every night 1/12/2016 increase Risperidone to 0.25 mg po q AM and continue 0.5 mg every night 5-3-2016 decrease Risperidone to 0.25 mg BID- GDR attempt" During further record review on 7/15/2016 at 1:34 p.m., the following was			

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	indicated: "General Note", dated 6/7/2016 and documented by LPN #34, indicated "Res. [resident] noted to have a lot of lethargy throughout the day, falling asleep at meals, will nap between meals. Res c/o [complain of] being tired frequently. Communicated to Rounding Providers." "Physician Order (new or change) " dated 6/7/2016 "Rounding Providers in this shift with the following n.o.[new order]: D/C [discontinue] melatonin d/t [due to] daytime lethargy and GDR [gradual dose reduction] attempt." A current, 4/14/2014, facility policy, titled " Psychotropic Drug Use Policy", was provided by DON on 7/15/2016 at 7:23 a.m., indicated: "Purpose: To ensure that medication regimen helps promote or maintain the resident's highest practicable mental, physical, and psychological well-being...each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s); non-pharmachological interventions are considered and used when indicated...Procedure: 1. The facility will assure that medication therapy is based upon an adequate indication for use by documenting the			

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	supporting diagnosis/ indication of use at the time of the order for psychotropic medication is obtained/ received. 2. On-going monitoring of target behaviors will be documented as they occur in the clinical record along with interventions used to reduce and the results...ANTIPSYCHOTIC indication for use Schizophrenia, Schizoaffective disorder, delusional disorder, Mood disorders (Mania, bipolar disorder, depression with psychotic features)...Dementing illness with associated behavioral symptoms...psychotic symptoms...." 3.1-37(a)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to place assistive devices as accessible leaving the resident restrained in bed for 1 of 30 residents reviewed (Resident #49). Findings include:	F 0323	Miller's Merry Manor respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation F 221. It is the policy of Miller's Merry Manor, Hartford City, that each resident has the right to remain free of any physical restraints imposed for the purposes of discipline or	08/11/2016

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	On 7/12/16 at 11:35 A.M., Resident #49 had a dressing to her forehead and bruises that covered the right side of her forehead down to the right side of the bridge of her nose. On 7/14/16 at 9:08 P.M., Resident #49 was laying in a low bed in her room. Her wheelchair and walker were in the hallway. During an interview, on 7/12/16 at 11:11 A.M., the Director of Nursing (DON) indicated Resident #49 fell in her room on 7/10/16 and had obtained an abrasion to her back and a hematoma to her forehead. During an interview, on 7/14/16 at 9:10 P.M., CNA #3 indicated Resident #49's wheelchair and walker were kept in the hallway, so she would not get out of bed and try to get into her wheelchair or use her walker without help. During an interview on 7/15/16 at 9:46 A.M., the DON indicated Resident #49 was attempting to get up out of bed to use the bathroom when she fell on 7/10/16. She further indicated Resident #49's walker and wheelchair were not in her room at the time of the fall. Furthermore, the DON indicated the walker and		convenience, and not required to treat the resident's medical symptoms. 1.The facility has reviewed Resident #49. The facility has also spoken to family regarding resident having access to assistive devices. Therapy has been requested to evaluate resident. New Fall risk assessment completed. All current interventions on fall prevention care plan have been reviewed by the IDT. Appropriate changes have been made to the plan of care. The changes made were:1. Therapy referral for evaluation. 2. Bed changed in room. Height of bed adjusted to enhance resident's ability to transfer more safely. 3. W/C will be accessible to resident in room. 4. Staff will continue ambulation with walker as per planof care. 2.Any resident who requires assistive devices for transfer/mobility have the potential to be affected if these devices are not available for use. The facility has reviewed all residents who use assistive devices for transfer and mobility. No other residents were found not to have devices available. 3.The facility will inservice all staff by 8/11/16. This education will include the definition of a restraint and the resident's right to have assistive devices available for use. It will also include implementation of appropriate interventions to	

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	wheelchair were not kept in her room because she was more apt to use her call light if they were not in there, according to Resident #49's family. The DON indicated she felt the removal of the wheelchair and walker from Resident #49's room was justified to keep the resident safe. She indicated that safety "trumped the risk of a head injury" and acknowledged how removing the aids could be a restraint, but had not assessed for them being restraints. Resident #49's clinical record review began on 7/13/16 at 10:02 A.M. Resident #49's diagnoses included, but were not limited to, heart failure, hypertension and dementia. Resident #49 had a current, 6/17/16, quarterly Minimum Data Set (MDS) assessment which indicated she was moderately cognitively impaired and heard and saw adequately. She also could understand and be understood adequately. She required extensive assistance with one person for bed mobility and transfers. She required limited, stand-by assistance with walking and used a walker and a wheelchair for mobility. Review of Resident #49's current, 6/7/16, care plan included the following:		reduce the risk for resident falls. 4.The Quality Improvement Audit Tool "Nursing Services Review" (Attachment A) will be completed by the DON/Designee daily for 4 weeks and weekly for 4 weeks. The QA team will then determine the appropriate frequency to continue monitoring after analyzing any concerns and improvements. Any concerns will be addressedimmediately and logged on the "Quality Improvement Problem Summary Log" (Attachment B). 5.All systemic changes will be in place by 8/11/16.	

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	"...Focus NEEDS LIMITED TO EXTENSIVE ASSIST W/ADLS DUE TO: Weakness, Debility, occasional incontinence, unsteady gait without assistive device... Interventions/Tasks 8-7-15 per care plan meeting, family wishes that resident be able to ambulate to and from dining room and to and from bathroom with assist...Will plan to keep walker and wheelchair out of residents [sic] room to try and deter resident from getting up unassisted, son agreed with plan and requests that staff walk with resident to keep from loosing [sic] independence and the ability to go out the [sic] family on outings... Focus RESTORATIVE WALKING PROGRAM... Interventions/Tasks Remove walker and wheelchair from room following completion of task... Focus Fall risk characterized by risk factors...Resident does not always call for staff assist as previously educated to do so. Resident is to have 1-a [one person assist] although not willing to comply most times even after education...			

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	Interventions/Tasks 2-17-16... Resident not to be left unattended in her room in her w/c [wheelchair] for safety concerns...." Review of documents titled, "Facility-Post Occurrence IDT & fall risk Assessment", multiple dates, and provided by the DON on 7/15/16 at 1:31 P.M., included the following: "...Date and time of occurrence 08/09/2015 15:00 [3:00 P.M.]... Root cause: Resident indicated that she was trying to get in her closet for her night gown...(resident did not ask staff for assistance in getting nightgown...) ...Date and time of occurrence 10/21/2015 18:45 [6:45 P.M.]... Root cause: Resident attemtped [sic] to self transfer and change into night clothes... ...Date and time of occurrence 02/17/2016 17:40 [5:40 P.M.]... Root cause: Resident indicated she was trying to get her night clothes from closet... Resident was sitting in chair resting prior to occurrence... IDT recommendations... Resident not to be left alone in room in wheelchair for safety concerns...			

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	...Date and time of occurrence 03/12/2016 11:00 [A.M.]... Root cause: Resident was attempting to mess with papers on top of her dresser. Resident was up in room unassisted... ...Date and time of occurrence 07/10/2016 22:00 [10:00 P.M.]... Root cause: Resident attempting to get up to go to bathroom unassisted..." Interventions that had been tried included: Staff to monitor when the resident leaves the dining room - staff to follow to her room to meet needs; brightly colored paper to remind the resident not to get up without assistance; educated multiple times on not getting up without assistance; Physical therapy ordered from January to March; and Offer to assist the resident to lay down in bed after lunch. 3.1-3(w) 3.1-45(a)(2)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or			

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	considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure food was prepared, distributed, and served under sanitary conditions. Of the facility's 52 residents, this deficient practice had the potential to impact 52 who were served food from the facility's kitchen. Findings include: 1. Kitchen sanitation tour, accompanied by the Dietary Manager on 7/11/16 at 6:41 p.m., indicated the following: a. A 8-inch and 10-inch Teflon frying pans. The 8-inch pan was located on the stovetop and the 10-inch pan was located on the sink to be washed. The pans had multiple scratch marks that were down to the metal where the Teflon was removed. The Dietary Manager discarded the scratched up Teflon pans after they were brought to her attention. b. A ready to use meat slicer had multiple, dried food particles, cream, pink and brown in color, on the slicer, the meat holder, the base, the black knobs and on the stainless steel cart. The Dietary Manager indicated the whole	F 0371	Miller's Merry Manor respectfully submits the following planof correction as credible allegation of compliance to the above mentioned regulationF 371. It is the policy of Miller's Merry Manor – Hartford City to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute and serve food under sanitary conditions. 1.On 7/11/16, Certified Dietary Manager immediately threw away the scratched 8-inch and 10-inch Teflon frying pans identified by the surveyor, to ensure they did not receive any more use. After kitchen sanitation tour, CDM conducted an audit of the condition of all other frying pans and cookware. 2.On 7/11/16, Certified Dietary Manager conducted an in-service with present staff regarding the meat slicer. Together,they took the slicer apart and cleaned it, per facility policy "Cleaning the Food Slicer". 2.No residents were identified to have an adverse effect as a result of this deficientpractice. All residents have the potential to be affected by this deficient practice. The immediate intervention rectified the issues. 1. Staff were re-educated to	08/11/2016

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	meat slicer and stainless steel cart needed to be cleaned. During an interview with the Dietary Manager on 7/11/16 at 7:29 p.m., she indicated the meat slicer should be torn apart, washed, sanitized, ran through the dish machine, air dried, reassembled and a clean plastic bag placed over it with the date cleaned. She further indicated the Teflon skillets should be inspected weekly for missing Teflon on scratched skillets and discarded. During an interview with the Dietary Manager on 7/15/16 at 3:15 p.m., she indicated there were 52 residents who ate from the kitchen on 7/11/16. A review of the "DAILY CLEANING SCHEDULE" dated July 2016, provided by the Dietary Manager on 7/15/16 at 3:45 p.m. indicated the following: "...Slicer - [clean] after [each] use...." The cleaning schedule indicated the meat slicer was last cleaned 7/10/16 and 7/11/16. During an interview with the Dietary Manager on 7/15/16 at 3:45 p.m., the Dietary Manager indicated she was unable to determine when the meat slicer was last used and the cleaning schedule		check cookware after washing and before using again to ensure worn items are not used for cooking or serving. A systemic change was made and the daily cleaning list now includes an assignment of inspecting cookware to ensure it is in usable condition. 2.On 7/12/16, Certified Dietary Managerconducted the same in-service regarding the “Cleaning the Food Slicer” policy with all Dietary staff. Staff were educated not only on cleaning and sanitation of the meat slicer, but also proper storage of the slicer with the clean cover. 4.Beginning the week of 8/1/2016, it will be the responsibility of the Certified Dietary Manager, or designee to complete the Quality Assurance Tool titled “Sanitation Checklist” (See Attachment E) on a weekly basis for four weeks, and then monthly for three months. The QA team will then determine the appropriate frequency to continue monitoring after analyzing any concerns and improvements. Any concerns will be addressed immediately and logged on the“Quality Improvement Problem Summary Log” (Attachment B). This will be followed and reviewed through the monthly facility Quality Improvement meeting. 5.All systemic changes will be completed by 8/11/16.	

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	indicated the meat slicer was last cleaned on 7/10/16 and 7/11/16, before it was observed unclean on 7/11/16. A review of a policy titled "Equipment and Utensils-Cleaning and Sanitizing," was provided by the Dietary Manager on 7/12/16 at 8:10 a.m., and indicated the following: 1. "...POLICY: It is policy that the food service area be maintained in a clean and sanitized manner." 2. PROCEDURE: The Dietary Manager is responsible for preparing, posting, and monitoring the daily, weekly, and monthly cleaning schedules. A. The Dietary Manager will check for the following: ...II. All utensils, counters, shelves, and equipment is kept clean, maintained in good repair and is free from breaks, corrosions, open seams, cracks and chipped areas. ...III. Plastic ware, china, and glassware that cannot be sanitized or is hazardous because of chips, cracks, or loss of glaze are			

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	discarded...." No further information was provided by exit from the facility on 7/15/16. 3.1-21(i)(3)			
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug			

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	Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were securely stored for 1 of 2 medication rooms (South Nurse's station). This practice had the potential to affect 32 residents residing on the South Hall of 52 residents residing in the facility. Findings include: During the initial tour of the building, beginning on 7/11/16 at 6:36 p.m., the South Hall medication room door was observed to be ajar, with the door touching the door frame, but not shut. The door was able to be pushed open freely with one hand, and when the door was let go, it only shut against the door frame. A resident and two visitors were in the sitting area just outside of the South nurse's station and CNA #23 was observed walking from behind the nurse's station area and down the hall in the direction of the south end of the building. There was no other staff observed in the of the South hall area.	F 0431	Miller's Merry Manor respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation F 431. It is the policy of Miller's Merry Manor - Hartford City to ensure that drugs and biologicals used in the facility are securely stored. 1.The auto closure on the medication room was addressed immediately by the maintenance director. All other doors with auto closures were also checked to ensure proper functioning. 2.All residents are at risk to be affected. There were no negative outcomes and have been no further issues noted. Medication rooms have been properly closing. 3.All staff were re-educated on importance of making sure auto-closing doors close completely. Charge Nurses also complete rounds on each shift to ensure medication room doors are closing properly. Maintenance will be notified immediately of any concerns with the function of the auto closing doors. 4.To ensure this does not recur the DON/Designee will complete the Quality Improvement Audit Tool "Nursing services Review" (Attachment A) daily for 4 weeks,	08/11/2016

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	LPN #17 was observed approaching the South hall unit from the 100 hallway. When asked about the medication room door, she pulled it shut with some force, indicating the door must not have been pulled shut, as the door had to be pulled hard to secure it. She further indicated the medication room was to be kept locked at all times. On 7/11/16 at 8:45 p.m., the DON indicated she was aware the medication door had to be pulled shut. On 7/15/16 at 11:24 a.m., the Maintenance Director indicated the door required only a small adjustment to the hardware for it to shut freely. Review of a policy, titled "STORAGE OF MEDICATIONS", dated 6/1/11, and provided by the DON on 7/14/16 at 2:23 p.m., indicated the following: "...b. Only... those lawfully authorized to administer medications...are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access...." 3.1-25(j) 3.1-25(k) 3.1-25(l)		weekly for 4 weeks, then monthly thereafter. Any concerns will be addressed immediately and then logged on the “Quality Improvement Summary Log” (Attachment B). The corrective actions will be monitored through the monthly Quality Improvement meeting to ensure ongoing compliance. 5.All systemic changes will be in place by 8-11-16.	

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F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens			

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	Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure proper handwashing practices and glove use were utilized for perineal care for 1 of 1 observations of perineal care (Resident #49). Furthermore, the facility failed to ensure proper handling of linens on the 100 Hall. This practice had the potential to effect 33 of 33 residents residing on the hall. Findings include: 1. During an observation of perineal care on 7/15/16 beginning at 11:18 A.M., CNA #1 donned gloves, and used a remote to raise Resident #49's bed. She then placed a gait belt around Resident #49's waist and asked Resident #49 to scoot up to the edge of bed a little more. CNA locked the brakes on Resident #49's walker and assisted her to standing with the gait belt. Resident #49 then used the walker to walk to the bathroom with the assistance of CNA #1. CNA #1 entered the bathroom and with her gloved hand, she grabbed a plastic trash bag and picked up a dirty brief from the floor. She then removed Resident #49's brief with the same gloves on and placed it in the plastic bag. CNA #1 then	F 0441	Miller's Merry Manor respectfully submits the following plan of correctionas credible allegation of compliance to the above mentioned regulation F 441. It is the policy of Miller's Merry Manor, Hartford City to establish andmaintain an Infection Control Policy designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. 1.Resident #49 had no adverse effects related to the citation. The staff member involved (CNA #1) was re-educated on proper procedures for providing perineal care. 2.There were no noted adverse effects related to the citation regarding linen handling. Staff member involved was re-educated on proper procedure for passing linens. 2. 1.All residents who require staff assistance with perineal care needs have the potential to be affected. No other concerns have been noted. Occurrence identified as an isolated incident. 2.All residents have the	08/11/2016

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	touched Resident #49's walker and doorframe to the bathroom as she walked out to retrieve a clean brief while wearing the same gloves. CNA #1 returned to the bathroom and with the same pair of gloves on, picked up a washcloth sitting on the sink and sprayed it with perineal cleanser. She then provided perineal care to Resident #49 and placed the washcloth in a plastic bag on the floor. CNA #1 used another washcloth and dried Resident #49's perineal area. CNA #1 removed her gloves, but did not wash her hands. She then used the gait belt and assisted Resident #49 as she walked out of the bathroom with her walker. CNA #1 picked up Resident #49's glasses and placed them on her as she walked out of her room into the hallway. She then assisted Resident #49 into her wheelchair. CNA #1 returned to Resident #49's bathroom, washed her hands, picked up the plastic bags and carried them out of Resident #49's room. During an interview on 7/15/16 at 11:32 A.M., CNA #1 indicated that was her normal routine for providing perineal care except she used the perineal care		potential to be affected by this deficit practice. No other concerns have been noted. Occurrence identified as an isolated incident. 3. 1.The facility does provide routine education per online in-services and face-to-face education on infection control. Staff skill checks are completed annually for CNAs and on an as-needed basis. The facility will re-educate all direct care staff on the proper procedure for providing perineal care for residents. There will also be return demonstration required for all staff that were educated. This will be completed by 8/11/16. 2.The facility does provide routine education per online in-services and face-to-face education on infection control. Environmental Supervisor or designee will complete skills checks with all Laundry personnel. The facility will re-educate all laundry staff on proper handling of linens by 8/11/16. Again there will be return demonstration required from all staff who were educated. 4.To ensure that infection control measures regarding perineal care and linen handling are followed according to policies and procedures, the QA Tool “Nursing Services	

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	spray instead of soap and water to cleanse Resident #49 because she accidentally knocked one of the washcloths on the floor and because Resident #49 was not soiled. She did not mention anything regarding glove use or handwashing. During an interview with the Director of Nursing (DON) on 7/15/16 at 1:31 P.M., she indicated CNA #1 should have changed her gloves after removing Resident #49's brief. A review of a policy titled "Peri Care", dated 01/01/2009, and provided by the In-service Director on 7/15/16 at 11:57 A.M., indicated the following: "...1. PURPOSE * To cleanse the perineum for prevention of infection, irritation and to contribute to the residents positive self-image. ...3. PROCEDURE A. Obtain necessary equipment and take to residents bedside. B. Explain procedure to resident and provide privacy. C. Wash hands. D. Position resident...		Review"(Attachment A) will be completed by the DON/Designee daily for 4 weeks, weekly for 4 weeks then monthly thereafter. Any identified issues will be addressed immediately. Concerns will be logged on the "Quality Improvement Summary Log" (Attachment B). All logs are reviewed and followed by the Quality Improvement Committee in the monthly Quality Improvement Meeting. 5.All systemic changes will be in place by 8/11/16.	

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	E. Apply gloves. F. Remove disposable brief or pad. ...I. Place brief or pad in plastic bag. J. Remove soiled gloves and wash hands. K. Fill wash basin with warm water and wet clean cloth with warm water from sink. L. Apply clean gloves. M. Female: Using peri care product and wet wash cloth, wash labia first. Always wash from front to back. Be sure to spread the labia and cleanse thoroughly. Rinse and dry completely. Turn the resident to the side and cleanse anal area thoroughly. Rinse and dry completely. ...O. Place soiled wash cloth in bag. P. Remove gloves and wash hands.			

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Q. Apply appropriate brief product and/or clothing.

...U. Wash hands...."

2. During a random observation on 7/14/16 at 12:34 P.M., Laundry Aide #2 removed hanging clothing from an uncovered linen cart. She then carried the clothing against her body into Room 109. She exited Room 109 with nothing in her hands. She then removed hanging clothing from the uncovered linen cart and carried them against her body into Room 107. She exited Room 107 with nothing in her hands.

During an interview on 7/14/16 at 12:59 P.M., Laundry Aide #2 indicated she did not know of any rules specifically in regards to passing linens.

During an interview with the Environmental Supervisor on 7/14/16 at 1:48 P.M., she indicated Laundry Aide #2 had not been in-serviced on how to prevent the spread of infection with linen passing, but she was told during orientation to try and keep clothing away from scrub tops.

A review of a document titled, "Laundry Orientation Checklist", with a start date

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	9/19/13 and end date 10/22/13, and provided by the Environmental Supervisor on 7/14/16 at 2:11 P.M., indicated Laundry Aide #2 was checked off on "Distributing Clean Linens". A review of a policy titled, "Linen Handling", dated 6/9/10, and provided by the Environmental Supervisor on 7/14/16 at 2:08 A.M., indicated the following: "...1. POLICY: * Linens and laundry are handled or transported in a manner to prevent the spread of infection and/or contamination. 2. GUIDELINES: ...F. Linen should not be held against the staff member's uniform during transport or delivery...." 3.1-18(j) 3.1-19(g)(1) 3.1-19(g)(2) 3.1-19(g)(3) Based on observation, interview, and			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record review, the facility failed to place assistive devices as accessible leaving the resident restrained in bed for 1 of 30 residents reviewed (Resident #49). Findings include: On 7/12/16 at 11:35 A.M., Resident #49 had a dressing to her forehead and bruises that covered the right side of her forehead down to the right side of the bridge of her nose. On 7/14/16 at 9:08 P.M., Resident #49 was laying in a low bed in her room. Her wheelchair and walker were in the hallway. During an interview, on 7/12/16 at 11:11 A.M., the Director of Nursing (DON) indicated Resident #49 fell in her room on 7/10/16 and had obtained an abrasion to her back and a hematoma to her forehead. During an interview, on 7/14/16 at 9:10 P.M., CNA #3 indicated Resident #49's wheelchair and walker were kept in the hallway, so she would not get out of bed and try to get into her wheelchair or use her walker without help. During an interview on 7/15/16 at 9:46 A.M., the DON indicated Resident #49			

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	155576	A. BUILDING 00 B. WING	07/15/2016

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	was attempting to get up out of bed to use the bathroom when she fell on 7/10/16. She further indicated Resident #49's walker and wheelchair were not in her room at the time of the fall. Furthermore, the DON indicated the walker and wheelchair were not kept in her room because she was more apt to use her call light if they were not in there, according to Resident #49's family. The DON indicated she felt the removal of the wheelchair and walker from Resident #49's room was justified to keep the resident safe. She indicated that safety "trumped the risk of a head injury" and acknowledged how removing the aids could be a restraint, but had not assessed for them being restraints. Resident #49's clinical record review began on 7/13/16 at 10:02 A.M. Resident #49's diagnoses included, but were not limited to, heart failure, hypertension and dementia. Resident #49 had a current, 6/17/16, quarterly Minimum Data Set (MDS) assessment which indicated she was moderately cognitively impaired and heard and saw adequately. She also could understand and be understood adequately. She required extensive assistance with one person for bed mobility and transfers. She required			

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	limited, stand-by assistance with walking and used a walker and a wheelchair for mobility. Review of Resident #49's current, 6/7/16, care plan included the following: "...Focus NEEDS LIMITED TO EXTENSIVE ASSIST W/ADLS DUE TO: Weakness, Debility, occasional incontinence, unsteady gait without assistive device... Interventions/Tasks 8-7-15 per care plan meeting, family wishes that resident be able to ambulate to and from dining room and to and from bathroom with assist...Will plan to keep walker and wheelchair out of residents [sic] room to try and deter resident from getting up unassisted, son agreed with plan and requests that staff walk with resident to keep from loosing [sic] independence and the ability to go out the [sic] family on outings... Focus RESTORATIVE WALKING PROGRAM... Interventions/Tasks Remove walker and wheelchair from room following completion of task... Focus			

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	Fall risk characterized by risk factors...Resident does not always call for staff assist as previously educated to do so. Resident is to have 1-a [one person assist] although not willing to comply most times even after education... Interventions/Tasks 2-17-16... Resident not to be left unattended in her room in her w/c [wheelchair] for safety concerns...." Review of documents titled, "Facility-Post Occurrence IDT & fall risk Assessment", multiple dates, and provided by the DON on 7/15/16 at 1:31 P.M., included the following: "...Date and time of occurrence 08/09/2015 15:00 [3:00 P.M.]... Root cause: Resident indicated that she was trying to get in her closet for her night gown...(resident did not ask staff for assistance in getting nightgown...) ...Date and time of occurrence 10/21/2015 18:45 [6:45 P.M.]... Root cause: Resident attemtped [sic] to self transfer and change into night clothes... ...Date and time of occurrence 02/17/2016 17:40 [5:40 P.M.]... Root cause: Resident indicated she was			

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	trying to get her night clothes from closet... Resident was sitting in chair resting prior to occurrence... IDT recommendations... Resident not to be left alone in room in wheelchair for safety concerns... ...Date and time of occurrence 03/12/2016 11:00 [A.M.]... Root cause: Resident was attempting to mess with papers on top of her dresser. Resident was up in room unassisted... ...Date and time of occurrence 07/10/2016 22:00 [10:00 P.M.]... Root cause: Resident attempting to get up to go to bathroom unassisted..." Interventions that had been tried included: Staff to monitor when the resident leaves the dining room - staff to follow to her room to meet needs; brightly colored paper to remind the resident not to get up without assistance; educated multiple times on not getting up without assistance; Physical therapy ordered from January to March; and Offer to assist the resident to lay down in bed after lunch. 3.1-3(w) 3.1-45(a)(2)			

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